

SOUTHERN NEW MEXICO SURGERY CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Southern NM Surgery Center to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire 365 days from the date of signature or at the date or event specified here (Expiration date/event) _____.

I further understand that I may revoke this authorization at any time by notifying, in writing, the Southern New Mexico Surgery Center facility where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand there is a charge for photocopies and records provided on electronic media as indicated below, as permitted by law, unless copies are sent directly to another healthcare provider.

Patient Name	Last 4 of Social Security Number	Date of Birth MM / DD / YYYY	Acct #
Street Address	City	Zip	Telephone Number

RELEASE OF THE INFORMATION FOR:

The following treatment dates _____ OR All treatment dates

INFORMATION TO BE RELEASED TO: Patient/Designee Health Care Entity Insurance Company
 Attorney OTHER _____

INDIVIDUAL/ ORGANIZATIONAL NAME	TELEPHONE #
STREET ADDRESS	CITY, STATE, ZIP
	FAX #

PURPOSE OF THE USE AND/OR DISCLOSURE: Continued Care Legal Insurance
 Personal Use Other _____

COPY FORMAT: Paper CD Electronic Email Address: _____

DELIVERY METHOD: Fax Mail Picked up in Person on site Electronic

INFORMATION TO BE RELEASED: Complete Medical Record Operative Report
 Billing Statements Other: _____

\$50 Medical Record Processing Fee Patient Only: No charge for operative report

I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting this request. PLEASE ALLOW UP TO 30 DAYS TO PROCESS REQUEST.

_____ Signature of Patient or Legal Representative (electronic signatures not acceptable)	_____ Date
_____ Printed Name of Patient or Legal Representative	_____ Relationship to Patient

The information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

PAYMENT AMOUNT: \$ _____ DATE RECEIVED: _____ DATE SENT: _____ INITIALS: _____